Supreme Court, U.S.
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No.

In The

Supreme Court of the United States

October Term, 1996

HEALTHSOUTH REHABILITATION HOSPITAL,

Petitioner,

vs.

AMERICAN NATIONAL RED CROSS d/b/a AMERICAN RED CROSS SOUTH CAROLINA BLOOD SERVICES REGION,

Respondent.

Petition for Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

This appeal raises the questions of whether estoppel principles are applicable to cases within the jurisdiction of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001, *et seq.*, brought under federal common law and whether the representations of an agent, acting within the scope of its authority, may be imputed to a plan governed by ERISA.

In enacting ERISA, Congress intended courts to fashion federal common law to fill in the gaps left by the statute. In so doing, however, the courts have had difficulty determining when and to what extent federal common law should be established. Specifically, federal courts of appeals have been divided over when federal common law estoppel principles may be used to establish liability under an ERISA plan. Some courts have chosen not to allow estoppel principles at all to modify the terms of a plan, *Nachwalter v. Christie,* 805 F.2d 956 (11th Cir. 1986), while others have allowed claims under estoppel principles to stand where the representations made and sought to be enforced interpreted rather than modified written terms of a plan, *Kane v. Aetna Life Ins.*, 893 F.2d 1283 (11th Cir. 1990), *cert. denied,* 498 U.S. 890 (1990). Finally, a group of courts have held that estoppel principles may be used to enforce representations made by plan administrators or their agents. *Taylor v. Peoples Natural Gas Co.*, 49 F.3d 982 (3d Cir. 1995). In addition, at least one circuit court has recognized that estoppel principles may be used to determine whether an individual is a participant or beneficiary of a plan, *Miller v. Taylor Insulation Co.*, 39 F.3d 755 (7th Cir. 1994).

This Petition asks that this Court set forth guidelines as to when and under what circumstances federal common law principles of estoppel may be used to enforce oral or written representations made by plan administrators or their

nonfiduciary agents. More specifically, this Petition asks that this Court set forth under what circumstances estoppel may be used to determine if an individual is a participant or beneficiary in an ERISA plan.

In addition, the court in *Taylor* found that a plan administrator may be held accountable for the actions of its nonfiduciary agent where that agent acts in the course and scope of its authority. This Petition therefore also asks that this Court designate when the acts or representations of a nonfiduciary agent may be imputed to the agent's principal, *i.e.*, the plan administrator.

Thus, this Petition asks the following questions: 1) Does the pervasive conflict among the circuits require a decision by this Court as to when and under what circumstances common law principles of estoppel should be incorporated into federal common law under ERISA; and (2) Should representations of a nonfiduciary agent made in the course and scope of its authority bind the plan administrator/principal?

PARTIES TO THE PROCEEDING

The summons and complaint filed in this matter included other parties not appearing in the caption of this petition. Causes of action against these parties were either resolved or settled prior to the hearing on Red Cross' Motion for Summary Judgment. Throughout the proceedings, HealthSouth Rehabilitation Hospital has been the only plaintiff. The original defendants included Aetna Life Insurance Company as well as Alberta Shaw, and Derrick Wagner, individually and as parents and natural guardians of Eric Shaw, a minor under the age of eighteen (18) years. HealthSouth obtained judgments against Alberta Shaw and Derrick Wagner on March 21, 1995 and an Order of Dismissal was entered as to Aetna Life Insurance Company on July 27, 1995.

RULE 29.6 LISTING

Pursuant to Rule 29.6, Petitioner HealthSouth Rehabilitation Hospital is a publicly traded corporation with no parent company or nonwholly owned subsidiaries.

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Petitioner, HealthSouth Rehabilitation Hospital of Florence ("HealthSouth"), respectfully petitions for a Writ of Certiorari to review the judgment of the United States Court of Appeals for the Fourth Circuit.

OPINION BELOW

The findings of fact and conclusions of law of the United States District Court for the District of South Carolina are unreported and are reprinted in Appendix C. The United States Court of Appeals for the Fourth Circuit affirmed the decision of the district court and issued a published opinion in this matter on December 3, 1996, which is reprinted in Appendix A. In addition, the United States Court of Appeals for the Fourth Circuit denied HealthSouth's Petition for a Rehearing and issued an Order which is reprinted in Appendix B.

STATEMENT OF JURISDICTION

The Fourth Circuit Judgment and opinion were rendered on December 3, 1996. This Court's jurisdiction is invoked under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

This Petition asks whether and in what circumstances estoppel principles may be used to enforce oral representations made by a plan administrator or its nonfiduciary agent. The Petitioner relies on the statutory provisions of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001, *et seq.* and the federal common law promulgated under ERISA. More specifically, many of the courts which have addressed this question have looked to whether 29 U.S.C. § 1102(a)(1) and 29 U.S.C. § 1102(b)(3) prohibit the use of federal common law estoppel principles to vary the terms of a written plan. Those sections state:

(a) Named fiduciaries

(1) Every employee benefit plan shall be established and maintained pursuant to a written instrument. Such instrument shall provide for one or more named fiduciaries who jointly or severally shall have authority to control and manage the operation and administration of the plan.

* * *

(b) Requisite features of plan
Every employee benefit plan shall —

* * *

(3) provide a procedure for amending such plan, and for identifying the persons who have authority to amend the plan, . . .

29 U.S.C. § 1102.

STATEMENT OF THE CASE

A. Factual Summary

On January 4, 1994, Eric Shaw, the minor son of Derrick Wagner and Alberta Shaw, was admitted to HealthSouth Rehabilitation Hospital ("HealthSouth") where he underwent treatment until February 17, 1994. On that same day, January 4, 1994, Kathy R. Dargan, Admissions Coordinator for HealthSouth, contacted the American National Red Cross ("Red

Cross") to verify that Derrick Wagner was an employee of Red Cross. Following her conversation with Red Cross, Ms. Dargan contacted Aetna Insurance Company of America ("Aetna") to verify that Eric Shaw was a beneficiary under the *For Your Benefit* Medical Plan ("the Plan") offered by Red Cross to its employees. Aetna serves as a claims administrator for Red Cross and performs certain administrative functions pursuant to an Administrative Services Contract between Red Cross and Aetna. At the time of Eric's admission to HealthSouth, his mother, Alberta Shaw, executed an Assignment of Benefits transferring all rights Eric had to benefits under the Plan to HealthSouth.

When Ms. Dargan contacted Aetna, she spoke to Kelley, an employee of Aetna, who advised that Eric Shaw was a beneficiary under the Plan, all of the deductibles applicable were waived, charges would be considered at one hundred percent (100%), and that pre-certification was required. In order to pre-certify coverage, an employee of HealthSouth contacted Millie, a case manager with Aetna, who pre-certified a seven (7) day stay for Eric, with a one (1) day overlap for care conference reports. Throughout Eric's treatment at HealthSouth, Miriam Bunch, a HealthSouth employee, remained in contact with Millie at Aetna by way of telephone and weekly conference reports. On February 15, 1994, Millie contacted HealthSouth and left a message that they had made a mistake and Eric Shaw was not a beneficiary under the Plan.

While at HealthSouth, Eric Shaw incurred medical bills totaling Eighty-Two Thousand Nine Hundred Sixty-Seven & 00/100 ($82,967.00) Dollars for which Red Cross was billed.

B. District Court Proceedings

Following Red Cross' denial of the claims submitted by HealthSouth, the Hospital brought suit on November 18, 1994

against Aetna Insurance Company of America, The American Red Cross, Alberta Shaw, and Derrick Wagner. With the exception of Red Cross, HealthSouth's claims have been settled or resolved against all defendants. HealthSouth seeks payment of benefits on behalf of Eric Shaw under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq.* on the theory that Aetna, acting as Red Cross' agent, orally confirmed that Eric Shaw was a beneficiary under the Plan. HealthSouth asserts that in making this representation, Aetna was "interpreting" the written Plan provisions rather than modifying those provisions. HealthSouth also alleges that Red Cross breached its fiduciary duties to HealthSouth, as Eric Shaw's assignee, in refusing to pay benefits under the Plan.

On June 15, 1995, Red Cross moved for summary judgment against HealthSouth on the grounds that HealthSouth lacked standing to sue and the district court lacked subject matter to hear HealthSouth's claims. Red Cross subsequently filed a Motion for a Partial Stay of Discovery which was granted on July 6, 1995. In response, HealthSouth filed a Motion to Compel Discovery which was denied on July 26, 1995. On August 2, 1995, the Honorable Cameron M. Currie heard and granted Red Cross' motion. On August 3, 1995, summary judgment was entered for Red Cross and the action was dismissed.

C. Appeal to the Fourth Circuit

HealthSouth appealed the granting of summary judgment to Red Cross on the grounds that the district court had erred in finding that Eric Shaw was not a beneficiary under the Plan and that summary judgment was improper when the Plaintiff had been denied the opportunity to obtain adequate discovery. HealthSouth also appealed the district court's decision to deny HealthSouth the opportunity to further amend its Complaint to state a cause of action for estoppel.

The Fourth Circuit affirmed the district court, holding that Aetna did not have the requisite discretionary authority to "make" Eric Shaw a beneficiary under the Plan. Further, even if Aetna had the authority to deem Eric Shaw a beneficiary, Aetna's representations were insufficient to modify the terms of the Plan, citing *Biggers v. Wittek Indus., Inc.*, 4 F.3d 291 (4th Cir. 1993), and *Coleman v. Nationwide Life Ins. Co.*, 969 F.2d 54, 58-59 (4th Cir. 1992), *cert. denied*, 506 U.S. 1081 (1993). The court further found that because HealthSouth did not have standing to bring suit against Red Cross, no amount of discovery would be sufficient to contravene the clear language of the plan. Finally, the court found that the district court had not erred in denying the plaintiff's request to amend its complaint rejecting any claim for common law estoppel under ERISA. The court rejected HealthSouth's argument that estoppel should be allowed under *Miller v. Taylor Insulation Co.*, 39 F.3d 755 (7th Cir. 1994), and *Hall v. Cropmate*, 887 F. Supp. 1193 (S.D. Ind. 1995).

REASONS FOR GRANTING THE WRIT

This Petition presents two important questions of federal law that have not been, but should be, settled by this Court: (1) Does the pervasive conflict among the circuits require a decision by this Court as to when and under what circumstances common law principles of estoppel should be incorporated into federal common law under ERISA; and (2) Should representations of a nonfiduciary agent made in the course and scope of its authority bind the plan administrator/principal?

Each day, health care providers telephone employers, administrators, and insurance companies to verify potential health care patients' benefits and coverage under plans presented to the provider by the patients. Out of these many phone calls arise disputes as to whether or not one party or another has misrepresented coverage to the provider spawning substantial

litigation throughout the country. This misrepresentation problem is not limited to health care but impacts every situation in the workplace where parties talk to each other about ERISA governed benefits. This Court has not ruled on the issue leaving tremendous uncertainty within the health care industry as to the parties' respective rights and liabilities in regard to these telephone conversations. As noted below, there is a conflict among the circuits as to when and under what circumstances, if at all, plans should be held to representations of their plan administrators or their nonfiduciary agents.

I.

THE FOURTH CIRCUIT'S DECISION CONFLICTS WITH THE DECISIONS OF OTHER COURTS OF APPEALS WITH REGARD TO WHEN AND UNDER WHAT CIRCUMSTANCES COMMON LAW PRINCIPLES OF ESTOPPEL SHOULD BE INCORPORATED INTO FEDERAL COMMON LAW UNDER ERISA.

In enacting ERISA, Congress intended the courts to "develop a 'federal common law of rights and obligations under ERISA-regulated plans.' " *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110 (1989) (*quoting Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 44 (1987)). The courts, however, have had some difficulty determining when federal common law "is a desirable companion to ERISA" and when "federal common law imposes an unwarranted and unacceptable expansion of those rights and remedies established by ERISA." *Singer v. Black & Decker Corp.*, 964 F.2d 1449, 1452 (4th Cir. 1992). In enacting federal common law, courts are to apply common law doctrines best suited to furthering the goals of ERISA rather than looking to the common law doctrines of a particular state. *Id.* "Consequently, federal common law should be consistent across the circuits. To the extent that inconsistencies arise, Congress and the Supreme Court are capable of harmonizing them." *Id.* at 1453.

In *HealthSouth Rehabilitation Hospital v. American Nat'l Red Cross*, 101 F.3d 1005 (4th Cir. 1996), the Fourth Circuit Court of Appeals found that the representations of Aetna, as Red Cross' agent, did not and could not "make" Eric Shaw a beneficiary under the Plan. This decision is in direct conflict with the Seventh Circuit's decision in *Miller v. Taylor Insulation Co.*, 39 F.3d 755 (7th Cir. 1994). In *Miller*, the court found that promissory estoppel was part of the common law Congress intended the courts to create in order to plug the gaps left by ERISA. *Id.* at 758 (citations omitted). The court found that an individual seeking to invoke principles of promissory estoppel to find that he was a plan participant was not preempted by ERISA. *Id.* at 759. The court noted the Eleventh Circuit's holding in *Kane v. Aetna Life Ins.*, 893 F.2d 1283 (11th Cir. 1990), *cert. denied*, 498 U.S. 890 (1990), that estoppel could not be invoked to allow oral modifications or informal amendments to plan provisions to modify the terms of a written plan but further stated:

> [t]here is no sense in which using promissory estoppel to allow into a written plan someone excluded by its own terms amounts to an oral modification of the terms of a written plan. The main objection, however, to oral modifications is that they would enable the plan's integrity, and possibly its actuarial soundness, to be eroded by relatively low-level employees who in response to inquiries about the scope of coverage advise participants that a particular medical procedure is covered, even though the plan is explicit that it is not covered. This concern is diminished when the doctrine is used to prevent an employer from denying that an employee (or as in this case a former

> employee) is a participant in the plan. Assurances that one is a participant, as distinct from assurance concerning the plan's coverage of a particular medical procedure, are unlikely to come from low-level employees, and is not in this case. We need not pursue the issue further. The promise in this case was written. Enforcing it would not collide with a policy against allowing oral modifications of ERISA plans.

Miller at 759 (citations omitted).

Generally, courts have been divided over whether to fashion federal common law based on estoppel principles under ERISA. *Coonce v. Aetna Life Ins. Co.*, 777 F. Supp. 759 (W.D. Mo. 1991). One of the first circuits to address whether common law estoppel principles would be allowed to stand was the Eleventh Circuit. *Nachwalter v. Christie*, 805 F.2d 956, 959 (11th Cir. 1986). In *Nachwalter*, the court held that written terms of a plan could not be modified by oral representations. *Id.* at 957. The court reasoned that though Congress intended the courts to establish federal common law principles to fill the gaps left in ERISA, this intent did not give federal courts *carte blanche* to apply *any* common law doctrines. Instead, common law doctrines may be applied when ERISA does not expressly address the issue. *Id.* at 959. The court found that because "ERISA expressly requires that employee benefit plans be 'established and maintained pursuant to a written instrument,' " oral modifications to a plan are prohibited and common law estoppel claims cannot be used to enforce those oral modifications. *Id.* at 960 (*quoting* 29 U.S.C. § 1102(a)(1)). Further, the court noted that because ERISA sets forth specific requirements regarding amendments to employee benefit plans, 29 U.S.C. § 1102(b)(3), informal written or oral amendments are ineffective. *Id.* Finally,

the court noted that allowing an estoppel claim would contradict the central goal of ERISA, to protect the interests of participants and beneficiaries in employee benefit plans, possibly effecting the financial integrity of these plans. *Id.*

After *Nachwalter*, some courts have chosen to follow the Eleventh Circuit's reasoning while others have not. *Black v. TIC Investment Corp.*, 900 F.2d 112, 114-15 (7th Cir. 1990). In *Black*, the court noted that the trend among the courts was to allow a claim for estoppel under ERISA. *Id.* at 114 (*citing Ellenburg v. Brockway, Inc.*, 763 F.2d 1091, 1096 (9th Cir. 1985); *Dockray v. Phelps Dodge Corp.*, 801 F.2d 1149, 1155 (9th Cir. 1986); *Landro v. Glendenning Motorways*, 625 F.2d 1344 (8th Cir. 1980); *Apponi v. Sunshine Biscuits, Inc.*, 809 F.2d 1210, 1217 (6th Cir. 1987), *cert. denied*, 484 U.S. 820 (1987); *Cleary v. Graphic Communications Int'l Union*, 841 F.2d 444, 447-49 (1st Cir. 1988); *Haeberle v. Board of Trustees*, 624 F.2d 1132, 1139 (2d Cir. 1980)). The court also recognized, however, that the Fourth, Tenth and Eleventh Circuits had refused to allow claims for estoppel under ERISA. *Id.* at 115 (*citing Straub v. Western Union Tel. Co.*, 851 F.2d 1262, 1264-66 (10th Cir. 1988); *Nachwalter v. Christie*, 805 F.2d 956-61 (11th Cir. 1986); *Holland v. Burlington Ind., Inc.*, 772 F.2d 1140, 1147 (4th Cir. 1985); *aff'd without opinion*, 477 U.S. 901 (1986) and *cert. denied*, 477 U.S. 903 (1986)); *see also Krawczyk v. Harnischfeger Corp.*, 41 F.3d 276, 280 (7th Cir. 1994); *Kraut v. Wisconsin Laborers Health Fund*, 992 F.2d 113, 117 (7th Cir. 1993); *Miller v. Coastal Corp.*, 978 F.2d 622 (10th Cir. 1992), *cert. denied*, 507 U.S. 987 (1993) (finding estoppel cannot be used to alter the written terms of a plan); *Coleman v. Nationwide Life Ins.* Co., 969 F.2d 54 (4th Cir. 1992). Since that time, other circuits have chosen to follow *Nachwalter's* reasoning that plans cannot be modified by oral or informal amendments. *See Jensen v. SIPCO, Inc.*, 38 F.3d 945, 953 (8th Cir. 1994), *cert. denied*, __ U.S. __, 115 S. Ct. 1428 (1995) (finding equitable estoppel

cannot be used to recover money damages but recognizing that the Eighth Circuit has left open the question of whether estoppel principles may give rise to an ERISA claim and noting that most courts have held that ERISA precludes oral or informal amendments to plan documents); *Slice v. Sons of Norway*, 34 F.3d 630, 632-33 (8th Cir. 1994) (holding that under *Mertens v. Hewitt Assocs.*, 508 U.S. 248 (1993) and *Novak v. Andersen Corp.*, 962 F.2d 757 (8th Cir. 1992), *cert. denied*, __ U.S. __, 113 S. Ct. 2928 (1993), a claim for equitable estoppel will not be allowed to stand where the relief sought is essentially money damages); *Law v. Ernst & Young*, 956 F.2d 364, 367-70 (1st Cir. 1992) (holding that plaintiff had not established elements necessary for common law estoppel claim nor established that his claim was actionable under ERISA); *Rodrigue v. Western and S. Life Ins. Co.*, 948 F.2d 969, 970-72 (5th Cir. 1991) (applying the reasoning proposed by the Seventh, Eighth, and Eleventh Circuits that the requirement that plans be maintained in writing precludes application of estoppel principles to vary the terms of a plan); *Hozier v. Midwest Fasteners, Inc.*, 908 F.2d 1155, 1163-64 (3d Cir. 1990) (oral or informal communications between and employer and plan beneficiaries did not constitute a plan amendment); *Degan v. Ford Motor Co.*, 869 F.2d 889 (5th Cir. 1989); *Moore v. Metropolitan Life Ins. Co.*, 856 F.2d 488, 492 (2d Cir. 1988) (holding that "an ERISA welfare plan is not subject to amendment as a result of informal communications between an employer and plan beneficiaries"). These courts have generally relied on the requirement that plans be maintained in writing and recognized ERISA's goal of protecting the actuarial soundness of pension plans to find that estoppel principles could not be allowed. *Coonce* at 770.

Though the majority of the circuits have chosen not to fashion a federal common law based on estoppel principles where the representations sought to be enforced vary the written terms of a plan, many courts have left open whether estoppel

may be applied in limited circumstances. *Fink v. Union Cent. Life Ins. Co.*, 94 F.3d 489, 492 (8th Cir. 1996); *Pisciotta v. Teledyne Ind., Inc.*, 91 F.3d 1326, 1331 (9th Cir. 1996) (holding that an ERISA beneficiary may bring a claim for estoppel where the beneficiary establishes a material misrepresentation, reasonable and detrimental reliance upon the representations and extraordinary circumstances, and that the provisions of the plan are ambiguous and the representations interpreted provisions of the plan); *In Re Unisys Corp. Retiree Medical Benefit "ERISA" Litigation*, 58 F.3d 896, (3d Cir. 1995); *Averhart v. US West Management Pension Plan*, 46 F.3d 1480 (10th Cir. 1994) (recognizing that the Eleventh and Ninth Circuits have found that claims for estoppel are viable when the representations sought to be enforced are interpretations of plan provisions but finding no ambiguous provisions in the plan); *Krawczyk v. Harnischfeger Corp.*, 41 F.3d 276, 280 (7th Cir. 1994) (recognizing the application of estoppel principles to unfunded benefit plans but refusing to address whether estoppel was available to enforce oral representations against funded benefit plans); *Miller v. Taylor Insulation Co.*, 39 F.3d 755, 758-59 (7th Cir. 1994); *Jensen v. SIPCO, Inc.*, 38 F.3d 945, 953 (8th Cir. 1994), *cert. denied*, __ U.S. __, 115 S. Ct. 1428 (1995); *Vershaw v. Northwestern Nat. Life Ins. Co.*, 979 F.2d 557 (7th Cir. 1992) (noting that "[e]stoppel is applicable to certain claims under ERISA" yet recognizing that "policies underlying ERISA require a preference for written over oral contract terms"); *Miller v. Coastal Corp.*, 978 F.2d 622, 625 (10th Cir. 1992), *cert. denied*, 507 U.S. 987 (1993); *Greany v. Western Farm Bureau Life Ins. Co.*, 973 F.2d 812 (9th Cir. 1992) (adopting reasoning in *Kane* that "the federal common law of equitable estoppel is not available to plaintiffs in cases involving oral amendments to or modifications of employee plans governed by ERISA because ERISA specifically addresses these issues"); *Law v. Ernst & Young*, 956 F.2d 364, 367-70 (1st Cir. 1992) (declining to address whether a cause of action for equitable estoppel was actionable

under ERISA). Those courts have found, as in *Kane v. Aetna Life Ins.*, 893 F.2d 1283 (11th Cir. 1990), *cert. denied*, 498 U.S. 890 (1990), "[f]or a representation to be an interpretation of a plan, the relevant provisions of the plan must be ambiguous, this is to say, 'reasonable persons could disagree as to [the provisions'] meaning and effect." *Novak v. Irwin Yacht and Marine Corp.*, 986 F.2d 468, 472 (11th Cir. 1993) (*citing Kane* at 1285).

Though some courts have chosen not to fashion a federal common law cause of action for estoppel, or have only done so in limited circumstances, some courts have allowed claims for estoppel. *Lincoln General Hosp. v. Blue Cross/Blue Shield of Nebraska*, 963 F.2d 1136, 1141 (8th Cir. 1992). In *Lincoln General Hospital*, the court allowed a claim for equitable estoppel but found that the plaintiff had not provided proof of "words or deeds (or sometimes omissions to speak or act) that create a misleading impression upon which a reasonable person would rely." *Id.* (*quoting Dyna-Tel, Inc. v. Lakewood Engineering & Mfg. Co.*, 946 F.2d 539, 543 (7th Cir. 1991) (citations omitted). *See also Sprague v. General Motors Corp.*, 92 F.3d 1425 (6th Cir. 1996); *Principal Mut. Life Ins. v. Charter Barclay Hosp.*, 81 F.3d 53 (7th Cir. 1996) (finding that even though estoppel is an available basis for claiming benefits under ERISA, the hospital had failed to prove reasonable reliance on plaintiff's representations); *Swinney v. General Motors Corp.*, 46 F.3d 512, 522 (6th Cir. 1995); *Cleary v. Graphic Communications Int'l Union*, 841 F.2d 444 (1st Cir. 1988); *Vastoler v. American Can Co.*, 700 F.2d 916, 918-19 (3d Cir. 1983) (finding summary judgment inappropriate when the presence of detrimental reliance was disputed). For example, in *Armistead v. Vernitron Corp.*, 944 F.2d 1287 (6th Cir. 1991), the defendant sought to avoid liability for representations it had made arguing that as in *Nachwalter*, the requirement that ERISA plans be maintained in writing precludes application of estoppel

principles to vary the terms of a plan. *Id.* at 1299. Recognizing the court's reasoning in *Nachwalter*, the Sixth Circuit pointed out that the concerns prevalent in *Nachwalter* were not applicable to insurance plans.

> The actuarial soundness of a fund, which might be depleted if strict vesting and accrual requirements were not observed, is not an issue where a plan of this description is involved. We conclude therefore that in such as case, the purpose of Congress in enacting 29 U.S.C. § 1102(a) would not be frustrated by recourse to estoppel principles, which are generally applicable to all legal actions.

Id. at 1300. The court therefore allowed claims under estoppel to stand.

Clearly, the circuit courts are divided as to when and under what circumstances federal common law principles of estoppel may be applied. In upholding the district court's denial of HealthSouth's Motion to Amend the Complaint to add a cause of action under estoppel, the court's decision conflicted with the decisions of other courts of appeals on the same issue. *See Miller v. Taylor Insulation Co.*, 39 F.3d 755 (7th Cir. 1994). Finally, as demonstrated above, in *HealthSouth Rehabilitation Hospital*, the Fourth Circuit decided an important issue of federal law which has not been, but should be, decided by this Court.

II.

THE FOURTH CIRCUIT'S DECISION IS IN CONFLICT WITH THE DECISION ON THE SAME ISSUE BY THE THIRD CIRCUIT IN *TAYLOR V. PEOPLES NATIONAL GAS CO.*

In its opinion, the Fourth Circuit Court of Appeals upheld the district court's conclusion that because Red Cross alone had discretionary authority over administration of the Plan, Aetna had no authority to "make" Eric Shaw a beneficiary under the Plan. Appendix A at 7a (citing 29 C.F.R. § 2509.75-8 (1994); *see also Haidle v. Chippenham Hosp. Inc.*, 855 F. Supp. 127, 131-32 (E.D. Va. 1994); *Baker Hosp. v. Aetna Life Ins. & Casualty Co.*, No. 91-2004, 1991 WL 179113 (unpublished) (4th Cir. 1991)). This conclusion, however, ignores the common law theory of agency which was adopted by the courts into federal common law in *Taylor v. Peoples Natural Gas* Co., 49 F.3d 982 (3d Cir. 1995); *see also Steinberg v. Mikkelsen,* 901 F. Supp. 1433 (E.D. Wis. 1995). In *Taylor,* a nonfiduciary agent of the plan administrator advised plan participants regarding their rights and options under the plan. *Id.* at 986. These representations were made within the scope of authority granted to *Taylor* by the plan administrator. *Id.* The court recognized that regulations promulgated by the Department of Labor provide that "[i]n discharging fiduciary responsibilities, a fiduciary with respect to a plan may rely on . . . persons who perform purely ministerial functions for such plan," such as "advising participants of their rights and options under the plan." *Taylor* at 987 (*citing* 29 C.F.R. § 2509.75-8, Q&A D-2 & FR-11).

Just as in *Taylor*, in the Administrative Services Agreement between Aetna and Red Cross, both Aetna and Red Cross agreed that "Aetna[,] in performing its obligations under this Contract[,] is acting only as agent of [Red Cross] and the rights and

responsibilities of the parties shall be determined in accordance with the law of agency." (Appendix F). In addition, the Administrative Services Agreement delegated to Aetna the authority to "make determinations on behalf of [Red Cross] with respect to benefit payments under the Plan and to pay such benefits. . . ." (Appendix F). Therefore, Aetna, in making representations to providers such as HealthSouth as to who was considered to be a beneficiary, was acting within the scope of their authority. Thus, under common law agency theories, Red Cross may be bound by Aetna's representations. *Id.* at 987-88.

In addition, in *Weaver v. Phoenix Life Mut. Ins. Co.*, 990 F.2d 154 (4th Cir. 1993), the Fourth Circuit held that a plan administrator could not avoid liability for failure to provide reasons for denial of benefits based on a contract with a utilization review firm. Though the Fourth Circuit did not allow the defendant in the *Weaver* case to shield itself from liability for decisions and representations made by its nonfiduciary agent, it has allowed Red Cross to shield itself from liability for representations made by Aetna.

Clearly, the court's decision in *HealthSouth* conflicts with the Third Circuit's decision in *Taylor v. Peoples Natural Gas Co.*, 49 F.3d 982 (3d Cir. 1995). In addition, by failing to recognize Aetna as Red Cross' agent, the Fourth Circuit's decision conflicted with its earlier decision in *Weaver.* The Petitioner, HealthSouth, therefore respectfully requests that this Court grant certiorari to review the Fourth Circuit's decision declining to address whether Red Cross could be held liable for the representations of its agent, Aetna, where Aetna was acting within the scope of authority granted to it by Red Cross.

CONCLUSION

This Court may take judicial notice of the fact that numerous transactions involving plans take place orally. ERISA's requirement that plans be written and maintained in writing applies to both plans and beneficiaries. To suggest that beneficiaries may not rely on oral representation is to beg the question of whether the Plan has liability for making oral representations in violation of the ERISA provision that the Plan be maintained in writing. If it is argued that both parties err by dealing with each other orally, it is unfair and unjust to apply all of the potential loss from maintaining oral dealings on the beneficiaries without applying any liability on the plan administrator for having provided the oral information, either directly or through their agent, to begin with.

Correcting this conflict between the circuits is this Court's opportunity to settle once and for all various parties' rights and responsibilities under ERISA as to oral communications. Without guidance or direction from this Court, hospitals in circuits such as the Fourth Circuit will be forced to obtain copies of all documentation of coverage and benefits prior to admitting the patient, obtain a written guarantee of payment from the plan, or simply require that the patient make appropriate deposits or guarantees of payment as if they did not participate in an employee benefit plan. At best, this would slow down the admission process and at worst could compromise patient care.

For these reasons a writ of certiorari should issue to review the judgment and Opinion of the Fourth Circuit.

Respectfully submitted,

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APPENDIX A — OPINION OF THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT DATED SEPTEMBER 27, 1996

HEALTHSOUTH REHABILITATION HOSPITAL, Plaintiff-Appellant,

v.

AMERICAN NATIONAL RED CROSS, d/b/a American Red Cross South Carolina Blood Services Region, Defendant-Appellee,

and

Aetna Insurance Company of America; Alberta Shaw; Derrick Wagner, individually and as Parents and Natural Guardians of Eric Shaw, a Minor under the age of Eighteen (18) Years, Defendants.

No. 95-2645.

United States Court of Appeals,
Fourth Circuit

Argued Sept. 27, 1996.

Decided Dec. 3, 1996.

Hospital brought Employee Retirement Income Security Act (ERISA) action against ERISA plan, plan's administrating company and parents of patient. The United States District Court for the District of South Carolina, Cameron M. Currie, J., granted summary judgment to plan's administrating company. Hospital

appealed. The Court of Appeals, Hamilton, Circuit Judge, held that: (1) company providing administrative and ministerial services to ERISA plan was not ERISA fiduciary or plan administrator and, thus, hospital lacked standing to bring ERISA action against company, and (2) hospital was not entitled to amend its complaint to add promissory estoppel causes of action against ERISA plan.

Affirmed.

* * *

ARGUED: Annette Roney Drachman, Laddaga, Crout & Drachman, P.A., Charleston, SC, for Plaintiff-Appellant. Daniel J. Westbrook, Nelson, Mullins, Riley & Scarborough, L.L.P., Columbia, SC, for Defendant-Appellee. ON BRIEF: Linda C. Garrett, Laddaga, Crout & Drachman, P.A., Charleston, SC, for Plaintiff-Appellant. Alice V. Harris, Nelson, Mullins, Riley & Scarborough, L.L.P., Columbia, SC, for Defendant-Appellee.

Before ERVIN and HAMILTON, Circuit Judges, and SPENCER, United States District Judge for the Eastern District of Virginia, sitting by designation.

Affirmed by published opinion. Judge HAMILTON wrote the opinion, in which Judge ERVIN and Judge SPENCER joined.

OPINION

HAMILTON, Circuit Judge:

This is a suit for damages filed by HealthSouth Rehabilitation Hospital (HealthSouth) pursuant to the Employee Retirement

Appendix A

Income Security Act of 1974 (ERISA), 29 U.S.C.A. §§ 1001-1461 (West Supp. 1995). The sole remaining defendant in this case is the American National Red Cross, South Carolina Blood Services Region (Red Cross). HealthSouth's claims against the other defendants have either been settled or resolved. The district court granted summary judgment to Red Cross, and we now affirm.

I.

Red Cross maintains "For Your Benefit," a self-insured ERISA welfare plan (Plan) for its employees. Red Cross is the plan administrator, and Aetna Life Insurance Company (Aetna) provides administrative and ministerial services to Red Cross pursuant to a contract. According to that contract, Aetna had the authority to make determinations on behalf of Red Cross with respect to benefit payments under the Plan and to pay out those benefits, subject to Red Cross's reserved right to modify any such determinations. Aetna had no contractual authority to modify the Plan by declaring coverage for non- covered procedures, nor to bestow beneficiary status on non-beneficiaries.

Derrick Wagner (Wagner) is a Red Cross employee and the natural father of Eric Shaw. Red Cross provides all employees with a summary Plan description, and according to practice, one was distributed to Wagner. That summary explains that an employee may enroll himself as a Plan participant and his spouse and dependent children as Plan beneficiaries. In June 1989, Wagner completed a Plan enrollment form in which he elected to obtain medical coverage for himself only. At first, Wagner checked the box "yes" to indicate coverage election for dependent children but then marked through the "yes" box and

checked "no" and initialed the change. No premium payments for Eric Shaw's coverage under the Plan were ever made by Wagner or received by the Red Cross. Accordingly, Eric Shaw never satisfied the Plan definition of "beneficiary."

On January 4, 1994, Alberta Shaw, Eric Shaw's mother, took Eric Shaw to HealthSouth, in Florence, South Carolina, for rehabilitation therapy. Alberta Shaw represented to HealthSouth that Eric was covered by Wagner's Red Cross Plan and signed a document assigning the right to all benefits payable from any and all insurance policies over to HealthSouth. Alberta Shaw also presented HealthSouth with an insurance card which advised health care providers to contact Aetna to certify hospital admissions or verify coverage. That card also states that it does not guarantee coverage.

Before HealthSouth admitted Eric, the hospital's Admissions Coordinator called an Aetna representative to verify coverage. That Aetna representative erroneously informed the Admissions Coordinator that Eric Shaw was a covered beneficiary under the Plan with no deductible and one hundred percent coverage for approved charges. A "confirmation fax" was also sent to Aetna by HealthSouth on January 4, 1994, but no response was received by HealthSouth to the confirmation fax until February 15, 1994.

Based on Aetna's oral assurances, Eric Shaw was admitted at HealthSouth and underwent treatment for several weeks. Throughout Eric's stay at the hospital, Aetna was called on a weekly basis to obtain precertification for additional days of treatment. That precertification was always orally given. However, on February 15, 1994, an Aetna employee contacted HealthSouth and stated that the earlier oral confirmation of

beneficiary status was in error. Aetna also informed HealthSouth for the first time that Eric Shaw was not a beneficiary under the Plan. HealthSouth discharged Eric Shaw on February 17, 1994, after he had incurred $82,967 in expenses. The hospital submitted that bill to Aetna, but Red Cross declined to pay because Wagner had never elected to secure coverage for Eric.

HealthSouth brought an action against Red Cross, Aetna, Derrick Wagner, and Alberta Shaw, seeking to recoup Eric Shaw's hospital bills. The hospital alleged two claims against Red Cross in its amended complaint. First, the hospital alleged that Aetna acted as Red Cross's designated agent when Aetna orally confirmed Eric Shaw's coverage under Wagner's health insurance plan with Red Cross. Accordingly, HealthSouth asserted that Aetna's "interpretation" modified the Plan and Red Cross was bound by that modification. HealthSouth further maintained that because of the modification, Eric Shaw became a beneficiary and Red Cross was liable for Eric Shaw's hospital costs of $82,967. Second, HealthSouth alleged that it had become a valid assignee of any rights Eric Shaw had under the Plan and because Red Cross refused to pay the benefits allegedly owed to Eric as a now "confirmed" beneficiary of the Plan, Red Cross had breached the fiduciary duties it owed to HealthSouth as assignee. 29 U.S.C.A. § 1104(a)(1).

Red Cross filed a motion for summary judgment, claiming that HealthSouth did not have standing to bring the suit because Eric Shaw was not a beneficiary or an employee of a qualifying ERISA plan. 29 U.S.C.A. § 1132(a). HealthSouth opposed summary judgment and in its memorandum in opposition, indicated that if the district court was inclined to grant summary judgment to Red Cross, HealthSouth requested leave to amend its complaint to add an estoppel claim. HealthSouth also objected to the discovery restrictions imposed on it by the district court.

Appendix A

The district court granted summary judgment to Red Cross and in so doing rejected all of HealthSouth's claims, including the attempt to amend its complaint. HealthSouth timely brought this appeal questioning the district court's grant of summary judgment on its modification claims, the district court's discovery ruling, and the district court's refusal to entertain its proposed amendment to the complaint to add a promissory estoppel theory of recovery.

II.

Whether Red Cross was entitled to summary judgment is a matter of law which we review de novo. Higgins v. E.I. DuPont de Nemours & Co., 863 F.2d 1162, 1167 (4th Cir. 1988). Granting summary judgment as a matter of law is appropriate when the pleadings, depositions, affidavits, and other documents in the record leave no issue of any material fact which needs to be passed on by a jury. Fed.R.Civ.P. 56(c). Accordingly, the moving party must negate any material issue of fact and prove its entitlement to judgment on the relevant legal principles. See Celotex Corp. v. Catrett, 477 U.S. 317, 323, 106 S.Ct. 2548, 2552-53, 91 L.Ed.2d 265 (1986). In determining whether a genuine issue has been raised, the court must construe all inferences and ambiguities in favor of the nonmoving party. United States v. Diebold, 369 U.S. 654, 655, 82 S.Ct. 993, 994, 8 L.Ed.2d 176 (1962).

III.

HealthSouth contends that the district court erred when it concluded that HealthSouth had no standing to bring its ERISA claims. We disagree.

Appendix A

In order to establish its right to derivative standing because of Alberta Shaw and Eric Shaw's assignment of rights, HealthSouth would have to show that Eric Shaw was somehow "made" a beneficiary by Aetna's oral assurances that Eric Shaw's hospital expenses would be covered. Other than the Secretary or a fiduciary, an ERISA action may be brought only by a "participant" or a beneficiary to an ERISA plan. 29 U.S.C.A. § 1132(a) (West 1994). ERISA defines "participant" as "any employee or former employee of an employer . . . who is or may become eligible to receive a benefit of any type from an employee benefit plan . . . or whose beneficiaries may be eligible to receive any such benefit." 29 U.S.C.A. § 1002(7). Therefore, a person who is neither a participant nor a beneficiary lacks standing to bring an ERISA action against a fiduciary or plan administrator. See Stanton v. Gulf Oil Corp., 792 F.2d 432, 434-35 (4th Cir.1986); see also Cromwell v. Equicor-Equitable HCA Corp., 944 F.2d 1272, 1277-78 (6th Cir.1991), cert. denied, 505 U.S. 1233, 113 S.Ct. 2, 120 L.Ed.2d 931 (1992).

HealthSouth maintains that because of Aetna's agreement with Red Cross, Aetna possessed either actual or apparent authority to confer beneficiary status on Eric Shaw. The district court correctly concluded, however, that any discretionary authority over administration of the Plan rested solely with Red Cross. See 29 C.F.R. § 2509.75-8 (1994); see also Haidle v. Chippenham Hosp., Inc., 855 F.Supp. 121, 131-32 (E.D.Va.1994); Baker Hosp. v. Aetna Life Ins. & Casualty Co., No. 91-2004, 1991 WL 179113 (unpublished) (4th Cir. October 25, 1991).[1] In order to have the authority to amend or alter an

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1. Although the opinion in Baker Hospital is unpublished and does not constitute precedential authority pursuant to Local Rule 36(c), we find its reasoning persuasive. In Baker Hospital, a hospital called Global Associates, Inc. (Global), the plaintiffs employer, to verify coverage for Sally Reese

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ERISA plan, Aetna would have to be a fiduciary and thus, be cloaked with discretionary control respecting management of the Plan, including the authority to dispose of Plan assets. 29 U.S.C. § 1002(21)(A). Given Aetna's limited role in processing claims under the Plan and reading a computer screen to determine who is and who is not covered, it is clear that Aetna is not a fiduciary under the Plan. See Baxter v. C.A. Muer Corp., 941 F.2d 451 (6th Cir.1991) (a claims processor that only had the power to pay out benefits according to the terms of the established plan was not an ERISA fiduciary); Baker v. Big Star Div. of the Grand Union Co., 893 F.2d 288, 290 (11th Cir.1989) ("An insurance company does not become an ERISA 'fiduciary' simply by performing administrative functions and claims processing within a framework of rules established by an employer."); Haidle. 855 F.Supp. at 131-32 (Processing and paying claims are administrative, not discretionary functions, and an entity seized of the obligation to simply make determinations about who and what is covered by looking at the Plan's clearly established language is not an ERISA fiduciary.).

However, even if Aetna were a fiduciary, the oral statements

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warren, as directed on the Aetna insurance benefit card. Thus, Global was performing the same sort of administrative duties for the Aetna insured policy in that case, as Aetna performs for the Plan at issue before us. Id. at *1-*2. In addition, just like the Aetna/Red Cross card at issue here, the Global/Aetna card stated that it did not guarantee coverage. Id. at *2. Even though a Global employee assured the hospital that Sally Reese warren was covered, we held that Global was not a fiduciary and as a non-fiduciary, its administrative processing decisions could not bind Aetna. Id. at *2. The panel also held that Aetna did not breach its fiduciary duties by delegating non-fiduciary authority to Global. Id. at *2-*3.

made by it would be insufficient to modify the terms of an established ERISA plan. In Biggers v. Wittek Indus., Inc., 4 F.3d 291 (4th Cir.1993), we held that oral and informal amendments to established ERISA plans are completely incapable of altering the specified terms of the plan's written coverage. Id. at 295; see also Coleman v. Nationwide Life Ins. Co., 969 F.2d 54, 58-59 (4th Cir.1992), cert. denied, 506 U.S. 1081, 113 S.Ct. 1051, 122 L.Ed.2d 359 (1993). ERISA requires that a plan be "established and maintained pursuant to a written instrument," 29 U.S.C.A. § 1102(a)(1), and that said written instrument must describe the formal procedures pursuant to which the plan can be amended, 29 U.S.C.A. § 1102(b)(3). Based on that clear statutory directive we have concluded that in order to be effective, "any modification to a plan must be implemented in conformity with the formal amendment procedures and must be in writing." Id. at 58.

Appendix I to the Red Cross Plan states that Red Cross's Board of Governors is the entity with the power to approve or reject amendments to the Plan after recommendation by the Board of Trustees. Aetna, therefore, does not have the authority to effect unilateral modifications to the Plan by giving erroneous information to potential benefit claimants like HealthSouth. Thus, nothing in the Plan, the Red Cross/Aetna contract, or any other written document before this court indicates that Aetna may unilaterally alter the plan by bestowing beneficiary status upon a previously non-covered individual. In short, if we adopted HealthSouth's position, the Plan at issue would be modified such that someone not entitled to benefits would be found entitled to benefits. That result flies in the face of ERISA's clear statutory language. See Coleman, 969 F.2d at 59. Accordingly, the district court correctly granted summary judgment to Red Cross on HealthSouth's modification claims.

Appendix A

IV.

HealthSouth also contends that it was not given an adequate opportunity to complete discovery. This argument is without merit.

A district court should refuse to grant summary judgment when an opposing party needs additional time to complete discovery and properly respond to the motion. See Anderson v. Liberty Lobby, 477 U.S. 242, 251 n. 5, 106 S.Ct. 2505, 2511-12 n. 5, 91 L.Ed.2d 202 (1986). In the instant matter, however, HealthSouth was provided with a copy of the Aetna/Red Cross contract as well as all other documents relevant to its standing to sue Red Cross. Unfortunately for HealthSouth, it simply has no derivative standing to bring an ERISA claim based on any actions taken by Aetna. No amount of discovery could have unearthed information which would contravene the clear language of the Plan and disturb the fact that Eric Shaw never was a Plan beneficiary.

V.

Apparently realizing the minimal chance of success on its modification claims, HealthSouth further maintains that the district court erred when it refused to allow it to amend its complaint to add an estoppel cause of action against Red Cross. We disagree.

The decision to grant a party leave to amend its pleadings rests within the sound discretion of the district court. See Sandcrest Outpatient Serv. v. Cumberland County Hosp. Sys., 853 F.2d 1139, 1148 (4th Cir.1988). Nevertheless, it is well settled that, "in the absence of any apparent or declared reason — such as

undue delay, bad faith, or dilatory motive on the part of the movant, . . . undue prejudice to the opposing party by virtue of allowance of the amendment, futility of amendment, etc.— the leave sought should, as the rules require, be freely given." Foman v. Davis, 371 U.S. 178, 182, 83 S.Ct. 227, 230, 9 L.Ed.2d 222 (1962). Moreover, delay in requesting the amendment is generally not a sufficient reason, by itself, to deny the requested motion. See Davis v. Piper Aircraft Corp., 615 F.2d 606, 613 (4th Cir.), cert. dismissed, 448 U.S. 911, 101 S.Ct. 25, 65 L.Ed.2d 1141 (1980). Delay, however, can be a sufficient reason for denial of leave when accompanied by futility or prejudice to the nonmovant. See Deasy v. Hill, 833 F.2d 38, 40 (4th Cir.1987), cert. denied, 485 U.S. 977, 108 S.Ct. 1271, 99 L.Ed.2d 483 (1988). Lastly, as long as its reasons are apparent, a district court's failure to articulate grounds for denying a plaintiffs leave to amend does not amount to an abuse of discretion. See Island Creek Coal Co. v. Lake Shore, Inc., 832 F.2d 274, 279 (4th Cir.1987).

According to HealthSouth, because Aetna is Red Cross's agent for the purpose of health benefit determinations, Aetna's declaration of coverage for Eric Shaw is binding on Red Cross. This is a claim that "sounds" in both state and federal promissory estoppel. HealthSouth concedes that it does not have any state law promissory estoppel claim because any such state claim falls within ERISA's broad preemption provision. See 29 U.S.C.A. § 1144; see also Shaw v. Delta Air Lines, Inc.. 463 U.S. 85, 96-97, 103 S.Ct. 2890, 2899-2900, 77 L.Ed.2d 490 (1983) (ERISA preemption is construed broadly and displaces any state law which relates to an ERISA plan or "if it has a connection with or reference to such a plan.").

Nor can HealthSouth proceed with a federal common law

estoppel claim, for we have already squarely rejected such a contention. See Singer v. Black & Decker Corp., 964 F.2d 1449, 1452 (4th Cir. 1992) ("[R]esort to federal common law generally is inappropriate when its application would conflict with the statutory provisions of ERISA, . . . or threaten to override the explicit terms of an established ERISA plan"); see also Degan v. Ford Motor Co., 869 F.2d 889, 895 (5th Cir.1989) (Use of estoppel principles to bring about an oral modification of a written ERISA plan would conflict with ERISA's preference for written agreements.). We have never recognized estoppel arguments which would serve to vary the terms of a written plan, see Coleman, 969 F.2d at 54,[2] a fact which HealthSouth cannot avoid. We are aware that leaving HealthSouth to bear the cost of Eric Shaw's hospital stay is an unsatisfying conclusion. However, ERISA simply does not recognize the validity of oral or non-conforming written modifications to ERISA plans. See 29 U.S.C. §§ 1102(a)(1), and 1102(b)(3).

The decisions of Elmore v. Cone Mills Corp., 23 F.3d 855 (4th Cir.1994), and Hall v. Cropmate, 887 F. Supp. 1193 (S.D.Ind.1995), do not require a different result. HealthSouth

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2. HealthSouth seeks to avoid our rulings which have disallowed oral modifications by claiming that no modification of the Plan at issue is necessary. According to HealthSouth, Eric Shaw could be a beneficiary under the Plan so there is no need to change the Plan's terms in order to afford it the relief it seeks. Essentially, HealthSouth maintains that all Aetna did was "interpret" the Plan's terms and designate Eric Shaw a beneficiary — all without modifying the Plan at all. Unfortunately for HealthSouth, we have already addressed this very sort of "interpretation" argument and rejected it in Coleman, 969 F.2d at 59 (Estopping a Plan Administrator from denying benefits to an individual who was not a participant, nor a beneficiary, would have the unmitigated effect of modifying the Plan's written terms — a result that is in clear conflict with the statute's requirements.).

cites Elmore for the proposition that a fiduciary in an ERISA action can now be estopped from denying plan coverage based on oral assertions made to a claimed beneficiary. That reliance is misplaced.

In Elmore, this court, sitting en banc, addressed the question of whether estoppel principles could be used to bind a plan fiduciary to oral modifications made before terms of the plan were written down and became binding. 23 F.3d at 863. The plan at issue in Elmore was adopted subsequent to the contract that formed the basis for the plaintiffs estoppel claim. Id. at 868. Thus, the alleged beneficiaries in Elmore did not seek to alter a pre-existing ERISA plan, they merely asked that a contract entered into prior to the ERISA plan's adoption be given binding effect. Id. The district court held that an estoppel claim could go forward on those facts. An equally divided en banc court affirmed that decision.

Thus, Elmore carries no precedential weight, see Arkansas Writers' Project v. Ragland, 481 U.S. 221, 234 n. 7, 107 S.Ct. 1722, 1730 n. 7, 95 L.Ed.2d 209 (1987), and HealthSouth's reliance on Elmore fails on that basis alone. In any event, a careful reading of the different opinions in Elmore shows that four of the judges who would have allowed an estoppel claim on the facts presented in Elmore would also reject HealthSouth's argument here. Judge Murnaghan took great pains in his concurring opinion, in which three other judges joined, to distinguish Elmore on its facts from Coleman and Singer. See Elmore 23 F.3d at 868-69 (Murnaghan, J., concurring). In determining that the district court was correct when it allowed the estoppel argument to proceed, Judge Murnaghan clearly did not take issue with either Singer or Coleman. Id. at 869. Specifically, Judge Murnaghan stated:

> Prior existence of the Plan when the contract was formed might have caused problems to arise. In Coleman v. Nationwide Life Ins. Co., we held that estoppel principles cannot be used to effect a modification of an existing ERISA benefit plan. In such a case, adoption of an estoppel theory "would require this court to rewrite the contract of insurance. . . ." Id. at 56. . . . I have no quarrel with any of these prior decisions in their proper context. However, here the Plan was created subsequent to the contract, so no such Plan existed when the contract came into existence.

Id. Consequently, even under Judge Murnaghan's approach in Elmore, Coleman and Singer mandate the failure of HealthSouth's estoppel claim here.

Similarly, Hall v. Cropmate is of no help to HealthSouth. In Hall, the district court for the Southern District of Indiana concluded that an estoppel claim could proceed on facts quite similar to the case before us. 887 F.Supp. 1193. The Indiana district court held that when an individual's claim concerns whether coverage is afforded by the plan, no modification need be undertaken, and an estoppel claim is cognizable in that instance. Id. at 1197. Although the district court's reasoning in Hall supports HealthSouth's argument, we will not, and cannot overturn our clear precedent in order to follow the Southern District of Indiana.[3] Again, Coleman made it clear that when a

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3. The decision by the Indiana district court may not be completely without support in the context of Seventh circuit jurisprudence. Hall

(Cont'd)

nonbeneficiary seeks to obtain benefits pursuant to an ERISA plan, any change to that plan, or interpretation of that plan, is a modification which is prohibited by ERISA's plain language. Coleman, 969 F.2d at 59.

In summary, we affirm the district court's refusal to allow HealthSouth to amend its complaint because allowing the amendment would have been futile and would have, at most, delayed the inevitable dismissal of all of HealthSouth's claims against Red Cross. See Deasy, 833 F.2d at 40.

VI.

For the reasons stated herein, the judgment of the district court is affirmed.

AFFIRMED.

(Cont'd)

principally relied on Miller v. Taylor Insulation Co., 39 F.3d 755 (7th Cir.1994), a case which apparently recognized the possibility of a promissory estoppel claim in the ERISA context. "... Taylor may be estopped to deny that Miller is a participants." Id. at 758. However, based on the authority of Coleman, which is the controlling authority an this Circuit, and the reasons set forth herein, HealthSouth cannot establish a promissory estoppel claim. HealthSouth proposes an oral modification to the Plan and Coleman rejects a claim of that nature. But see id., at 759.

APPENDIX B — PETITION FOR REHEARING OF THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT FILED JANUARY 3, 1997

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

No. 95-2645
CA-94-3022-22

HEALTHSOUTH REHABILITATION HOSPITAL

Plaintiff - Appellant

v.

AMERICAN NATIONAL RED CROSS, d/b/a American Red Cross South Carolina Blood Services Region

Defendant - Appellee

and

AETNA INSURANCE COMPANY OF AMERICA; ALBERTA SHAW; DERRICK WAGNER, individually and as Parents and Natural Guardians of Eric Shaw, a Minor under the age of Eighteen (18) Years

Defendants

On Petition for Rehearing with Suggestion for Rehearing In Banc

The appellants petition for rehearing and suggestion for rehearing in banc were submitted to this Court. As no member of this Court or the panel requested a poll on the suggestion for rehearing in banc, and

Appendix B

As the panel considered the petition for rehearing and is of the opinion that it should be denied,

IT IS ORDERED that the petition for rehearing and suggestion for rehearing in banc are denied.

For the Court,

s/ Patricia S. Connor
CLERK

APPENDIX C — JUDGMENT OF THE UNITED STATES DISTRICT COURT, DISTRICT OF SOUTH CAROLINA FILED AUGUST 3, 1995

UNITED STATES DISTRICT COURT
DISTRICT OF SOUTH CAROLINA

CASE NUMBER: 4:94-3024-22

Healthsouth Rehabilitation Hospital,

Plaintiff

v.

American National Red Cross d/b/a American Red Cross South Carolina Blood Services Region, Alberta Shaw and Derrick Wagner, individually and as Parents and Natural Guardians of Eric Shaw, a Minor under the age of Eighteen (18) years, Defendants.

☒☒ **Decision by Court.** This action came to hearing before the Court and defendant's motion for summary judgment having been duly heard and granted.

IT IS ORDERED AND ADJUDGED that summary judgment is hereby entered for the Defendant, American National Red Cross, and the Plaintiff Healthsouth Rehabilitation Hospital take nothing and this action is hereby dismissed.

AUGUST 3, 1995
Date

LARRY W. PROPES
Clerk

s/ Tish Singletary
Deputy Clerk Tish Singletary

APPENDIX D — EXCERPTS OF TRANSCRIPT OF PROCEEDINGS DATED AUGUST 2, 1995

UNITED STATES DISTRICT COURT
DISTRICT OF SOUTH CAROLINA
FLORENCE DIVISION

CIVIL ACTION
NO. 4:94-3024-22

HEALTHSOUTH REHABILITATION HOSPITAL,

PLAINTIFF,

—VS.—

AMERICAN NATIONAL RED CROSS,

DEFENDANT.

UNITED STATES COURTHOUSE.
FLORENCE, SOUTH CAROLINA
WEDNESDAY, 2:30 P.M.,
AUGUST 2, 1995.

TRANSCRIPT OF HEARING PROCEEDINGS

BEFORE THE HONORABLE CAMERON M. CURRIE,
DISTRICT JUDGE

APPEARANCES: M. ANNETTE RONEY, ESQ.
CHARLESTON, SOUTH CAROLINA,
FOR THE PLAINTIFF.

Appendix D

DANIEL J. WESTBROOK, ESQ.
SUZANNE C. MASSEY, ESQ.
COLUMBIA, SOUTH CAROLINA,
FOR THE DEFENDANT.

STENOGRAPHIC REPORTING AND COMPUTER-AIDED TRANSCRIPTION VINCE ROLLAND, P.O. BOX 2317, FLORENCE SC 29503 (803) 662-1223

* * *

[26] EMPLOYEE'S COVERAGE, HIS OWN COVERAGE, NOT A BENEFICIARY ISSUE.

ALL RIGHT. I'M GOING TO RELUCTANTLY GRANT THE MOTION FOR SUMMARY JUDGMENT. I DON'T LIKE THIS, BUT I'M AFRAID THE LAW REQUIRES IT.

I MAKE THE FOLLOWING FINDINGS OF FACT IN THE LIGHT MOST FAVORABLE TO THE PLAINTIFF, HEALTHSOUTH. THAT THE ERISA PLAN AT ISSUE, THE RED CROSS PLAN, IS A WELFARE BENEFIT PLAN THAT IS SELF-INSURED BY RED CROSS FOR ITS EMPLOYEES, AND THAT RED CROSS IS THE PLAN ADMINISTRATOR AND AETNA PROVIDES ADMINISTRATIVE SERVICES FOR THE PLAN PURSUANT TO AN AGREEMENT. THAT THIS AGREEMENT WAS IN EFFECT JANUARY AND FEBRUARY, 1994, AND IN THE AGREEMENT, RED CROSS DELEGATED TO AETNA THE AUTHORITY TO MAKE DETERMINATIONS ON BEHALF OF RED CROSS WITH RESPECT TO BENEFIT PAYMENTS UNDER THE PLAN, AND TO PAY SUCH BENEFITS, SUBJECT, HOWEVER, TO THE RIGHT OF RED CROSS TO REVIEW AND MODIFY

ANY SUCH DETERMINATION. THE SUMMARY PLAN DESCRIPTION WHICH RED CROSS PROVIDES TO ALL OF ITS EMPLOYEES EXPLAINS TO THESE EMPLOYEES THAT THEIR COSTS FOR MEDICAL PLAN COVERAGE ARE DEPENDENT ON WHETHER YOU CHOOSE COVERAGE FOR YOURSELF ONLY, OR YOURSELF AND YOUR ELIGIBLE DEPENDENTS. THIS SUMMARY PLAN DESCRIPTION EXPLAINS HOW AN EMPLOYEE MAY ENROLL HIMSELF AS A PLAN PARTICIPANT, AND HIS SPOUSE AND DEPENDENT CHILDREN AS PLAN BENEFICIARIES. IT ALSO SETS FORTH PROCEDURES FOR EMPLOYEES AS TO THE ENROLLMENT STATUS, AS TO ENROLLING [27] HIMSELF, SPOUSES AND DEPENDENT CHILDREN.

IN JUNE OF 1989, RED CROSS EMPLOYEE DERRICK WAGNER COMPLETED AN ENROLLMENT FORM IN WHICH HE ELECTED TO OBTAIN MEDICAL COVERAGE FOR ONLY HIMSELF. ON THE SECTION OF THE FORM WHERE HE WAS ASKED WHETHER HE ELECTED COVERAGE FOR DEPENDENT CHILDREN, HE FIRST CHECKED YES, BUT THEN SCRATCHED THIS OUT AND INITIALED THE CHANGE. HE THEN CHECKED NO. TO THE NEXT QUESTION, WHICH WAS HOW MANY CHILDREN, HE WROTE ZERO. MR. WAGNER SIGNED AND DATED THE ENROLLMENT FORM JUST BELOW A STATEMENT THAT SAID HE RECEIVED PRINTED MATERIALS EXPLAINING THE BENEFIT PLAN AND HIS OPTIONS UNDER THE PLAN, TWO, THAT PAYROLL DEDUCTIONS WOULD RESULT FROM HIS ELECTION. AND THREE, THAT ALL INFORMATION ENTERED IN THE FORM WAS CORRECT.

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AT THE TIME HE FILLED OUT THIS ENROLLMENT FORM, HE WAS THE FATHER OF A MINOR CHILD NAMED ERIC SHAW, WHO LIVED WITH HIS MOTHER, ALBERTA SHAW. MS. SHAW AND MR. WAGNER HAVE NEVER BEEN MARRIED. THE MEDICAL PLAN IDENTIFICATION CARD THAT MR. WAGNER RECEIVED SPECIFICALLY ADVISED HEALTH CARE PROVIDERS TO CONTACT AETNA TO CERTIFY HOSPITAL ADMISSION OR TO VERIFY COVERAGE. THE CARD ALSO STATES THAT WHILE COVERAGE REMAINS IN FORCE, COVERED EMPLOYEES AND DEPENDENTS ARE ENTITLED TO BENEFITS AS PROVIDED UNDER THE TERMS AND CONDITIONS OF THIS EMPLOYER'S BENEFIT PROGRAM, AND THIS CARD DOES NOT GUARANTEE COVERAGE.

ON JANUARY 4, 1994, MS. SHAW TOOK ERIC TO THE [28] PLAINTIFF HOSPITAL WHERE HE WAS ADMITTED FOR MEDICAL TREATMENT AND INCURRED MEDICAL BILLS. SHE REPRESENTED TO THE HOSPITAL THAT ERIC WAS COVERED BY MR. WAGNER'S RED CROSS PLAN. SHE SIGNED A DOCUMENT ASSIGNING TO THE HOSPITAL THE RIGHT TO ALL BENEFITS PAYABLE FROM ANY AND ALL INSURANCE POLICIES. EMPLOYEE BENEFIT PLANS AND/OR LEGAL ACTIONS FROM WHICH SHE WAS ENTITLED TO RECOVER. BEFORE THIS ADMISSION, THE HOSPITAL ADMISSIONS COORDINATOR, KATHY DARGAN, CONTACTED AN AETNA REPRESENTATIVE WHO INFORMED MS. DARGAN THAT ERIC WAS COVERED UNDER THE RED CROSS PLAN. MS. DARGAN FAXXED A CONFIRMATION FAX ON JANUARY 4, 1994. TO THE AETNA REPRESENTATIVE NAMED MILLIE STATING THAT BASED ON A TELEPHONE CALL EARLIER THAT DAY,

THE HOSPITAL UNDERSTOOD THAT ERIC SHAW WAS COVERED UNDER THE RED CROSS PLAN WITH NO DEDUCTIBLE AND 100 PERCENT COVERAGE FOR APPROVED CHARGES. THE HOSPITAL RECEIVED NO RESPONSE TO THIS FAX UNTIL FEBRUARY 15, 1994. WHEN MILLIE LEFT A VOICE MAIL MESSAGE WITH THE HOSPITAL STATING THAT ERIC WAS NOT COVERED AND THAT PRIOR VERIFICATION HAD BEEN A MISTAKE. THROUGHOUT ERIC'S STAY AT THE HOSPITAL, AETNA WAS CONTACTED ON A WEEKLY BASIS TO OBTAIN PRECERTIFICATION FOR ADDITIONAL DAYS OF TREATMENT. ERIC WAS RELEASED FROM THE HOSPITAL ON FEBRUARY 17, AFTER INCURRING $82,967 IN EXPENSES. HEALTHSOUTH SUBMITTED THAT BILL TO AETNA. AETNA AND RED CROSS DENIED PAYMENT ALLEGING THAT ERIC WAS NOT A BENEFICIARY OF THE RED CROSS PLAN AT THE TIME OF ADMISSION, BECAUSE MR. WAGNER HAD NOT ELECTED TO OBTAIN [29] COVERAGE FOR ERIC.

THE HOSPITAL ARGUES THAT AETNA MODIFIED THE PLAN SO AS TO DESIGNATE ERIC AS A BENEFICIARY. THIS ARGUMENT IS BASED ON TWO THEORIES, ONE, THAT THE TELEPHONE CONVERSATION BETWEEN THE HOSPITAL AND AETNA MODIFIED THE PLAN, AND TWO, THAT THE CONFIRMATION FAX AND THE FAILURE OF AETNA TO IMMEDIATELY CONTEST THE INFORMATION IN THE FAX ALSO EFFECTED A MODIFICATION.

RED CROSS CONTENDS THAT PLAINTIFF'S ARGUMENT SHOULD FAIL BECAUSE THE ALLEGED MODIFICATIONS WERE NEITHER WRITTEN BY THE

AUTHORIZED PARTY, RED CROSS, NOR WERE THEY DONE UNDER THE FORMAL AMENDMENT PROCEDURES SET FORTH IN THE PLAN DOCUMENTS. TWO, THAT THERE IS NO EVIDENCE THAT RED CROSS EXHIBITED A CLEAR MANIFESTATION OF INTENT TO MODIFY THE PLAN, AND THREE. BOTH AETNA AND THE HOSPITAL LACK THE AUTHORITY TO MODIFY THE PLAN.

PLAINTIFF ARGUES THAT UNDER THE AGREEMENT, AETNA HAD THE AUTHORITY TO DETERMINE WHETHER AND IN WHAT AMOUNT AN INDIVIDUAL WAS ENTITLED TO RECEIVE COVERAGE UNDER THE RED CROSS PLAN, AND THAT THEREFORE, THE AGREEMENT GAVE AETNA EXPRESS AUTHORITY FROM RED CROSS TO DETERMINE BENEFICIARIES UNDER THE PLAN. THE COURT FINDS THAT HEALTHSOUTH'S ARGUMENT AS TO AETNA'S AUTHORITY TO MODIFY THE RED CROSS PLAN SO AS TO INCLUDE ERIC AS A BENEFICIARY FLIES IN THE FACE OF THE CLEAR LANGUAGE OF THE AETNA/ RED CROSS AGREEMENT. THE AGREEMENT [30] CLEARLY STATES THAT AETNA'S AUTHORITY TO MAKE DETERMINATIONS ON BEHALF OF RED CROSS WITH RESPECT TO BENEFIT PAYMENTS UNDER THE PLAN AND PAY SUCH BENEFITS IS SUBJECT, HOWEVER, TO THE RIGHT OF RED CROSS TO REVIEW AND MODIFY ANY SUCH DETERMINATION. FURTHERMORE, THE MEDICAL PLAN IDENTIFICATION CARD THAT MR. WAGNER RECEIVED STATES THAT WHILE COVERAGE REMAINS IN FORCE, COVERED EMPLOYEES AND DEPENDENTS ARE ENTITLED TO BENEFITS AS PROVIDED UNDER THE TERMS AND CONDITIONS OF THIS EMPLOYERS BENEFIT PROGRAM. RED CROSS,

THEREFORE, DID NOT GIVE AETNA THE AUTHORITY TO MODIFY THE PLAN SO AS TO ADD BENEFICIARIES.

THEREFORE, BECAUSE MR. WAGNER DECIDED NOT TO ENROLL ERIC UNDER THE RED CROSS PLAN, ERIC WAS NEVER A BENEFICIARY, AND HAD NO RIGHTS TO ASSIGN TO HEALTHSOUTH. THEREFORE, HEALTHSOUTH HAS NO STANDING TO BRING THIS ACTION UNDER ERISA.

THIS CONCLUSION IS SUPPORTED BY THE CASE OF HAIDLE VS. CHIPPENHAM HOSPITAL, INC., 855 F. SUPP. 127, WHICH IS AN EASTERN DISTRICT OF VIRGINIA CASE, 1994, WHERE THE COURT HELD THAT EVEN A LETTER FROM AETNA TO A HEALTH CARE PROVIDER INDICATING THAT A PERSON WOULD BE COVERED FOR SERVICES RENDERED BY THE HEALTH CARE PROVIDER COULD NOT CHANGE THE CLEAR AND UNAMBIGUOUS LANGUAGE OF THE PLAN THAT PRECLUDED COVERAGE. PLAINTIFF'S ATTEMPTS HERE TO DISTINGUISH HAIDLE. BY NOTING THAT IN HAIDLE, THE LETTER CONFIRMING COVERAGE STATED THAT IT WAS NOT A GUARANTEE OF BENEFITS, ARE NOT PERSUASIVE. [31] FIRST, IN THIS CASE, THE ALLEGED CONFIRMATION OF BENEFITS WAS ORAL INSTEAD OF WRITTEN, AS IT WAS IN HAIDLE. SECOND, THE MEDICAL PLAN IDENTIFICATION CARD STATED THAT COVERED EMPLOYEES AND DEPENDENTS ARE ENTITLED TO BENEFITS AS PROVIDED UNDER THE TERMS AND CONDITIONS OF THE EMPLOYER'S BENEFIT PROGRAM. THIRD, THE IDENTIFICATION CARD ALSO STATED THAT IT WAS NOT A GUARANTEE OF BENEFITS. THEREFORE, SUMMARY JUDGMENT IS

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ENTERED IN FAVOR OF THE DEFENDANT RED CROSS ON THE FIRST TWO CAUSES OF ACTION, AND I WOULD ALSO CITE CROMWELL VS. EQUICOR-EQUITABLE, 949 F. 2D 1272, PAGE 1278, SIXTH CIRCUIT, 1991. AND LORDMAN ENTERPRISES VS. EQUICOR. 32 F. 3D 1529, PAGES 1534 AND 1535, ELEVENTH CIRCUIT, 1994.

MS. RONEY, THIS IS UNFORTUNATELY ANOTHER ONE OF THOSE CASES THAT FALLS IN THAT GAP THAT I REFERRED TO IN MY DECISION IN COLLETON VS. M.R.S. THAT CONGRESS IS GOING TO HAVE TO FIX. IF IT'S TO BE FIXED. THE COURTS CANNOT SOLVE THIS PROBLEM. UNFORTUNATELY, THERE IS A GAP OR A HOLE IN ERISA, AND THIS IS IT. THIS IS ANOTHER CASE THAT FALLS SQUARELY IN IT. FORTUNATELY, YOU'VE BEEN ABLE IN THIS CASE TO SETTLE WITH AETNA SO YOU HAVE SOME RELIEF FOR YOUR CLIENT. IT'S VERY UNFAIR TO THE HOSPITAL. I AGREE WITH YOU. BUT HOSPITALS ARE GOING TO HAVE TO LOBBY THE CONGRESS TO CLOSE THIS GAP. I'M SORRY. SUMMARY JUDGMENT IS ENTERED.

(THEREUPON. THE PROCEEDINGS WERE CONCLUDED.)

* * *

APPENDIX E — PLAINTIFF'S NOTICE OF MOTION FILED JULY 11, 1995

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
FLORENCE DIVISION

CASE NO.: 4:94-3024-22

HEALTHSOUTH REHABILITATION HOSPITAL,

Plaintiff,

-versus-

AETNA LIFE INSURANCE COMPANY, AMERICAN NATIONAL RED CROSS d/b/a AMERICAN RED CROSS SOUTH CAROLINA BLOOD SERVICES REGION, ALBERTA SHAW, and DERRICK WAGNER, INDIVIDUALLY, AND AS PARENTS AND NATURAL GUARDIANS OF ERIC SHAW, A MINOR UNDER THE AGE OF EIGHTEEN (18) YEARS,

Defendants.

PLAINTIFF'S NOTICE OF MOTION AND MOTION TO COMPEL DISCOVERY

ERISA NON-JURY/COLLECTION ACTION

PLEASE TAKE NOTICE that the Plaintiff above named, through undersigned counsel, will move before the United States District Court, District of South Carolina, Florence Division, Honorable Cameron M. Currie, presiding, on the tenth (10th)

day after service hereof, at 10:00 a.m., or as soon thereafter as counsel may be heard, for an Order.

Compelling the Defendant, Red Cross, to respond to discovery previously served by the Plaintiff's Motion is based upon Rule 37(a)(2) of the Federal Rules of Civil Procedure.

APPENDIX F — EXCERPTS OF AGREEMENT

AETNA
LIFE & CASUALTY

No. 654028

ADMINISTRATIVE SERVICES
CONTRACT NUMBER ASC-654028

Agreement entered into between

THE AMERICAN NATIONAL RED CROSS

(hereinafter referred to as the "Contractholder")

and

AETNA LIFE INSURANCE COMPANY

Hartford, Connecticut

(hereinafter referred to as "Aetna")

WHEREAS, the Contractholder has adopted an employee benefit plan, hereinafter designated as the "Plan", which is set forth in Appendix I to this Contract, for certain of its employees and their dependents, under which Plan the Contractholder retains all liabilities; and

WHEREAS, the Contractholder has requested Aetna to provide certain administrative services to the Plan, and Aetna has agreed to provide such services in accordance with the terms of this Contract without assuming any liability of the Contractholder under the Plan;

NOW, THEREFORE, in consideration of the mutual promises

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and covenants contained in this Contract, it is hereby agreed as follows:

* * * * * * * * * * * * * * *

Section 4. Administration Charge

The administration charge made to the Contractholder for services performed by Aetna under this Contract will be determined by Aetna, following the close of a contract period, by applying Aetna's then current cost allocation formulae to the characteristics and mode of administration of the Contractholder's Plan for that contract period. This cost determination will take into account:

(a) the amounts of benefits paid and the number of benefit payments for the various kinds of benefits;

(b) the number of employees and dependents covered for the various kinds of benefits;

(c) the general type of benefit payment system used;

(d) the type of administrative record-keeping system used;

* * * * * * * * * * * * * * *

(a) Aetna in performing its obligations under this Contract is acting only as agent of the Contractholder and the rights and responsibilities of the parties shall be determined in accordance with the law of agency,

Appendix F

except as otherwise herein provided. The Contractholder hereby delegates to Aetna authority to make determinations on behalf of the Contractholder with respect to benefit payments under the Plan and to pay such benefits, subject, however, to a right of the Contractholder to review and modify any such determination. For the purposes of the Federal "Employee Retirement Income Security Act of 1974" and amendments and any applicable state legislation of similar nature, the Contractholder shall, however, be deemed the administrator of the Plan.

Supreme Court, U.S.
FILED
MAY 5 1997
CLERK

No. 96-1572

In The

Supreme Court of the United States

October Term, 1996

HEALTHSOUTH REHABILITATION HOSPITAL,

Petitioner,

vs.

AMERICAN NATIONAL RED CROSS d/b/a AMERICAN RED CROSS SOUTH CAROLINA BLOOD SERVICES REGION,

Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

RESPONDENT'S BRIEF IN OPPOSITION

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70817
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Lutz Appellate Services, inc.

RULE 29.6 LISTING

Respondent American National Red Cross is a private, not-for-profit corporation with no parent company and no nonwholly owned subsidiaries.

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Taylor v. The Peoples Natural Gas Co., 49 F.3d 982 (3rd Cir. 1995) 4, 9, 10

Weaver v. Phoenix Life Mut. Ins. Co., 990 F.2d 154 (4th Cir. 1993) 4, 11

Rule Cited:

Supreme Court Rule 10 .....5, 9, 11

STATEMENT OF THE CASE

A. Nature of the Case

Petitioner HealthSouth Rehabilitation Hospital ("HealthSouth") has petitioned for a writ of certiorari (the "Petition") to review a decision by the United States Court of Appeals for the Fourth Circuit affirming summary judgment for Respondent American National Red Cross ("Red Cross").

B. Statement of Facts

At the hearing on Red Cross's motion for summary judgment, the district court made the following findings of fact, in the light most favorable to HealthSouth. Petition *Appendix D* at 20a-23a.

The ERISA plan at issue (the "Plan") is a welfare benefits plan, self-insured by Red Cross for its employees. Red Cross is the Plan Administrator, while Aetna Insurance Company of America ("Aetna") provides administrative services pursuant to a contract with Red Cross (the "Contract"). Under the Contract, Aetna is authorized to make determinations on behalf of Red Cross with respect to benefit payments under the Plan and to pay such benefits, subject to Red Cross's right to review and modify any such determinations.

In June 1989 Red Cross employee Derrick L. Wagner completed an Employee Enrollment Form, in accordance with Plan procedures. Mr. Wagner elected to obtain medical coverage under the Plan for himself, but not for anyone else. The Medical Plan identification card (the "Plan ID Card") that Mr. Wagner received advised health care providers to contact Aetna to certify hospital admission or to verify coverage. The card further stated that while coverage remained in force, covered employees and

dependents were entitled to benefits as provided under the terms and conditions of the employer's benefits program. The card specifically stated that it did not guarantee coverage.

At the time Mr. Wagner completed the Employee Enrollment Form he was the father of a minor child, Eric Shaw, who lived with his mother, Alberta Shaw. On January 4, 1994, Ms. Shaw took Eric to HealthSouth, where he was admitted as an inpatient. Prior to Eric's admission, Ms. Shaw represented to HealthSouth that Eric was covered under Mr. Wagner's Red Cross plan. Ms. Shaw signed a document purporting to assign to HealthSouth "the right to all benefits payable from any and all insurance policies, employee benefit plans, and/or legal actions from which I am entitled to recover." In response to HealthSouth's telephone inquiry, an Aetna representative, identified only as "Kelley," informed HealthSouth that Eric was covered under the Red Cross plan. HealthSouth attempted to confirm coverage by faxing a letter (the "Confirmation Fax") to an Aetna representative, identified only as "Millie," on January 4, 1994. Throughout Eric's stay, Aetna was contacted on a weekly basis to obtain precertification for additional days of treatment. HealthSouth received no response to the Confirmation Fax until February 15, 1994, when Millie left a voice mail recording with HealthSouth stating that Eric was not covered and that prior verification had been a mistake. Two days later, Eric was discharged after having incurred $82,967 in medical bills.

C. Procedural History

In November 1995 HealthSouth filed suit in the United States District Court, District of South Carolina, bringing state law claims against Ms. Shaw and Mr. Wagner and ERISA claims against Aetna and Red Cross. HealthSouth obtained default judgments on its state law claims and settled with Aetna. In August 1995 the district court denied HealthSouth's motion to

amend its complaint to add an estoppel action under federal common law and granted summary judgment to Red Cross. The court of appeals affirmed in a published decision. *See HealthSouth Rehabilitation Hospital v. American National Red Cross*, 101 F.3d 1005 (4th Cir. 1996).

SUMMARY OF THE ARGUMENT

The issue addressed by the lower courts in this action was whether oral representations by a non-fiduciary claims processor to a hospital can estop a plan administrator from denying coverage under a welfare benefits plan. This was a narrow question that reflected the specific facts of the case. Recognizing that such an issue is unlikely to be reviewed by this Court, HealthSouth's Petition presents a far broader question for review, asking the Court to establish guidelines for determining generally when federal estoppel claims should apply in ERISA actions. Such a question is overly broad and inappropriate, since it was not addressed below.

Whether the issue is framed narrowly or broadly, it is not the subject of a pervasive conflict among the federal circuits. Because the circumstances surrounding ERISA cases vary widely, decisions among and within the circuits often vary as to whether estoppel can apply. However, HealthSouth can identify only one case, *Miller v. Taylor Insulation Co.*, 39 F.3d 755 (5th Cir. 1994), that arguably conflicts with the Fourth Circuit's decision in the present action. The arguable conflict arises from dicta in *Miller* that discusses policy issues applicable to circumstances not present in the case at hand. The *Miller* dicta cannot fairly be characterized as representing a "pervasive conflict" among the circuits.

HealthSouth also asks this Court to determine whether representations of a non-fiduciary agent made in the course and

scope of its authority bind a plan administrator/principal. The question presented in the lower courts, however, was *whether* Aetna was acting within the scope and course of its authority. In affirming the district court's finding that Aetna did *not* make a representation "in the course and scope of its authority," the Fourth Circuit plainly did not reach the issue presented by HealthSouth.

HealthSouth cites *Taylor v. The Peoples Natural Gas Co.*, 49 F.3d 982 (3rd Cir. 1995) and *Weaver v. Phoenix Life Mut. Ins. Co.*, 990 F.2d 154 (4th Cir. 1993) as being in conflict with *HealthSouth*. This comparison, however, boils down to an assertion that the Fourth Circuit misapplied properly stated rules of law. HealthSouth also tries to support its claims that Aetna could designate anyone it wanted as a plan beneficiary by quoting language from the Administrative Services Agreement between Aetna and Red Cross. The Fourth Circuit specifically found, however, that nothing in the Plan, the Red Cross/Aetna contract, or any other written document indicated that Aetna could unilaterally alter the plan by bestowing beneficiary status upon a previously non-covered individual.

REASONS FOR DENYING THE WRIT

I.

NO NEED EXISTS FOR THE SUPREME COURT TO SET GUIDELINES GOVERNING THE APPLICATION OF ESTOPPEL TO ALL ERISA ACTIONS.

A. The First Question Presented By HealthSouth In Its Petition Is Overly Broad And Was Neither Raised Nor Addressed By The Courts Below.

HealthSouth requests this Court to "set guidelines" for determining "when and under what circumstances common law

principles of estoppel should be incorporated into federal common law under ERISA." Petition at *i*, *ii*. The scope of such a question goes far beyond what was addressed in this action by the courts below and requires this Court to anticipate a wide variety of factual contexts. By seeking guidelines to govern all instances in which a party seeks to apply federal estoppel in an ERISA action, HealthSouth confuses the function of this Court with that of a regulatory agency.

HealthSouth first raised the issue of estoppel at oral arguments before the district court on Red Cross's motion for summary judgment. HealthSouth raised the issue in the context of a motion to amend its complaint by adding a federal common law estoppel claim, which the court denied, apparently on grounds of futility. In affirming the district court's denial of the motion to amend, the court of appeals addressed the following issue: under federal common law, can inaccurate oral representations by a non-fiduciary claims processor to a hospital that a non-beneficiary is covered under a welfare benefits plan estop the plan administrator from denying coverage, when the claims processor is the plan administrator's agent for the purpose of health benefit determinations? *See* 101 F.3d at 1009, 1010. The courts below were not presented with and did not address the broader estoppel question presented by HealthSouth in its Petition to this Court. Because this broader issue was not addressed below, the considerations governing review on certiorari listed in Supreme Court Rule 10 do not support the granting of HealthSouth's Petition.

B. No Pervasive Conflict Exists Among The Circuits Concerning The Application Of The Federal Common Law Of Estoppel To Erisa Actions.

HealthSouth contends that a "pervasive conflict" over the relationship between estoppel and ERISA divides the federal

circuits. As support, HealthSouth identifies three categories of cases:

> 1. those holding that the written terms of an ERISA plan cannot be modified by oral representations, Petition at 8-10;
>
> 2. those allowing estoppel claims in ERISA cases, Petition at 9, 12; and
>
> 3. those that "have left open whether estoppel may be applied in limited circumstances," Petition at 10-11.

HealthSouth's categories do not represent a conflict among the circuits, however. Several circuits are represented in more than one category. The reason, of course, is that ERISA cases arise from a wide variety of factual contexts, some of which may justify the application of estoppel and some of which may not.

HealthSouth suggests, for example, that an internal conflict exists within the Eleventh Circuit since one of its decisions rejects estoppel in an ERISA case while another allows it. *See* Petition at *i*, *comparing Nachwalter v. Christie*, 805 F.2d 956 (11th Cir. 1996) *with Kane v. Aetna Life Ins.*, 893 F.2d 1283 (11th Cir. 1990). The holdings of these cases, however, are not inconsistent. *Nachwalter* refused to estop an ERISA plan administrator from denying benefits based on oral representations that would have modified the plan's written terms. 805 F.2d at 957-960. *Kane*, by contrast, estopped an administrator from denying benefits based on its agent's oral interpretation of an ambiguous plan provision. 893 F.2d at 1286. The *Kane* opinion noted that its result was premised "entirely on the language" of the particular plan at issue. *Id.*

HealthSouth's conclusory allegation of a pervasive conflict among the circuits is no more substantial than the purported internal conflict within the Eleventh Circuit. After all its categories and string cites, the Petition can identify only one case, *Miller v. Taylor Insulation Co.*, 39 F.3d 755 (7th Cir. 1994), which it contends is in conflict with the Fourth Circuit's decision in *HealthSouth*. *See* Petition at 13.

In *Miller*, an employer made a written promise to a former employee, which he accepted and relied upon, that he could continue to participate in a welfare benefits plan after his retirement. 39 F.3d at 757. *HealthSouth* is fundamentally distinguishable in several respects:

1) No promise was made in *HealthSouth*, for the Plan ID card presented to HealthSouth specifically refused to guarantee coverage. Petition *Appendix D* at 22a.

2) The representations upon which HealthSouth relied were oral, not written.

3) The representations were not made by a high ranking employee of a fiduciary but by a low level employee of a non-fiduciary agent.

4) Unlike the *Miller* plaintiff, who accepted the offer of being a plan participant, Red Cross's employee Derrick Wagner declined Red Cross's offer to enroll his son as a beneficiary.

In dicta the *Miller* court speculated that the public policy justifications for the rule against oral modifications of ERISA plans may not apply to a promissory estoppel claim arising from assurances by an employer's high-ranking representative to an employee that he is a plan participant. *Id.* The facts in

HealthSouth are clearly distinguishable from such a hypothetical case, however. More significantly, *Miller* specifically noted that its holding "would not collide with a policy against allowing oral modifications of ERISA plans," 39 F.3d at 759 — the very policy upheld by the Fourth Circuit in *HealthSouth.*

Miller and *HealthSouth* are therefore distinguishable. But even if the *Miller* dicta suggests a conflict, the two cases hardly represent a pervasive conflict among the circuits requiring this Court to promulgate a broad "set of guidelines" applicable to all ERISA cases.

II.

THE *HEALTHSOUTH* DECISION IS NOT BASED ON ERRONEOUS FACTUAL FINDINGS OR THE MISAPPLICATION OF PROPERLY STATED RULES OF LAW.

HealthSouth frames the second question it presents to this Court as whether "representations of a non-fiduciary agent made in the course and scope of its authority bind the plan administrator/principal." Petition at *ii*. The question offered for review skips the initial issue of *whether* Aetna was acting within the scope and course of its authority. The court of appeals affirmed the district court's factual finding that "Red Cross . . . did not give Aetna the authority to modify the plan so as to add beneficiaries." 101 F.3d at 1008-1009; Petition *Appendix D* at 24a-25a. The court concluded that:

> Aetna . . . does not have the authority to effect unilateral modifications to the Plan by giving erroneous information to potential

> benefit claimants like HealthSouth. Thus, nothing in the Plan, the Red Cross/Aetna contract, or any other written document before this court indicates that Aetna may unilaterally alter the plan by bestowing beneficiary status upon a previously non-covered individual.

101 F.3d at 1009. In order to reach the second question presented in the Petition, this Court would therefore have to overturn the factual findings of the courts below. Review under these circumstances is hardly appropriate. *See* Sup. Ct. R. 10.

HealthSouth contends that the court's conclusion in *HealthSouth* "ignores the common law theory of agency" adopted in *Taylor v. The Peoples Natural Gas Co.*, 49 F.3d 982 (3rd Cir. 1995). Petition at 14. By this, HealthSouth is asserting that the court misapplied a properly stated rule of law, another questionable basis for granting a certiorari petition. *See* Sup. Ct. R. 10. *Taylor* did not formulate a unique "theory" of agency but instead considered two main issues: (1) whether a non-fiduciary benefits supervisor employed by a plan sponsor could be considered the agent of a plan administrator; and, (2) whether the supervisor had actual or apparent authority to make representations on behalf of the plan administrator to the plan sponsor's employees concerning the retroactivity of an early retirement plan. The court decided that the supervisor was acting, at a minimum, with apparent authority on behalf of the plan administrator. This decision hinged on the uncontested fact that the plan participants reasonably relied on the supervisor for guidance about their retirement plan and the defendant's admission that the supervisor had actual authority to advise employees of their rights and options under the plan. *Id.* at 988-989.

In contrast, the Fourth Circuit in *HealthSouth* considered a completely different question: whether Aetna, by its oral assurances, somehow "made" Eric Shaw a beneficiary. *Id.* at 1008. The court first rejected HealthSouth's argument that Aetna possessed either actual or apparent authority to confer beneficiary status on Eric Shaw because the district court had correctly concluded that "any discretionary authority over administration of the Plan rested solely with Red Cross." *Id.* at 1008. Aetna, as a claims processor, was not a fiduciary who could alter the plan's terms. *Id.* at 1009. The court also noted that even if Aetna were a fiduciary, its oral statements would be insufficient to modify the terms of an established ERISA plan. *Id. Taylor* thus lends no support to HealthSouth's position. While the holdings in both *Taylor* and *HealthSouth* implicate the issue of a non-fiduciary agent's authority, they involve wholly dissimilar facts.

HealthSouth further attempts to bolster its claims that Aetna could designate anyone it wanted as a Plan beneficiary by quoting language from the Administrative Services Agreement between Aetna and Red Cross. Petition at 14, 15. HealthSouth fails to note that Aetna's authority to make determinations with respect to benefit payments is "subject, however, to a right of [Red Cross] to review and modify any such determination." *See* Petition *Appendix D* at 24a. As the district court concluded, HealthSouth's position "flies in the face of the clear language" quoted here. Petition *Appendix D* at 24a. The Fourth Circuit also specifically noted that "nothing in the Plan, the Red Cross/ Aetna contract, or any other written document before this court indicates that Aetna may unilaterally alter the plan by bestowing beneficiary status upon a previously non-covered individual." *HealthSouth*, 101 F.3d at 1009.

Finally, HealthSouth claims that "by failing to recognize Aetna as Red Cross's agent, the Fourth Circuit's decision

conflicted with its earlier decision in *Weaver*." Petition at 15. HealthSouth is again presenting an argument that was not addressed by the Fourth Circuit and asserting that the court misapplied a properly stated rule of law. *See* Sup. Ct. R. 10. In addition, besides the fact that both *Weaver v. Phoenix Life Mut. Ins. Co.*, 990 F.2d 154 (4th Cir. 1993) and *HealthSouth* are ERISA cases, it is difficult to determine how they can be compared. *Weaver* never discusses agency and the two cases address completely different issues.

Weaver involved an insurance company that denied benefits to a participant and a beneficiary and failed to provide the "specific reason" for the claim denial as required under ERISA and the corresponding regulations. *Id.* at 157. The insurance company sought to avoid responsibility by noting that the standards on which an independent health care utilization review firm based its decision, and which would provide the specific reasons for the claim denial, were unavailable because they were the review firm's proprietary information. *Id.* at 157. The court held that "[p]lan administrators may not evade their responsibility under ERISA by contracting to third parties the obligations they have under ERISA" and must instead ascertain the specific reasons for the denial of claimed benefits and provide such reasons to the beneficiary. *Id.* at 158. In contrast, HealthSouth never asserted that Red Cross was withholding information from a participant or beneficiary and Red Cross has not sought to avoid responsibility of any kind by claiming that Aetna held proprietary information that was not available to Red Cross. Once again, HealthSouth relies upon a case that does not provide relevant authority.

CONCLUSION

For the reasons discussed above, HealthSouth's Petition for Writ of Certiorari should be denied.

Respectfully submitted,

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